The Princeton Center for Dermatology

Name: _____ Date of Birth: _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid: Hypo or Hyper
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed:
    Endometriosis
    Cyst
    Ovarian Cancer
    Other: _____
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy:
    Fibroids
    Uterine Cancer
    Other: _____
NONE

Other_____

Turn over to complete side 2

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

Other_____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)?
_____

Medications: (Please enter all current medications)
_____
_____
_____
_____

Allergies: (Please enter all allergies)
_____
_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Preferred Language: _____

Race:_____ Ethnic Group:_____

Preferred pharmacy Name: _____

Phone#: _____ City:_____ Zip Code_____

Review of Systems: Please check if you are currently experiencing any of the following.

Symptom	YES		YES
Allergy to adhesive		Allergy to lidocaine	
Allergy to antibiotic ointment		Artificial heart valve	
Artificial joint last 2 years		Blood thinners	
Defibrillator		History of MRSA	
Pacemaker		Premedication prior to procedures	
Rapid heartbeat with epinephrine		Pregnancy or planning pregnancy	
Problems with bleeding		Problems with healing	
Problems with scarring (hypertrophic or keloid)		Immunosuppression	
Thyroid problems		Joint aches	
Anxiety		Depression	
Chest Pain		Fever or Chills	
Night Sweats		Unintentional weight loss	
Blurry Vision		Abdominal pain	
Bloody Stool		Bloody urine	
Muscel weakness		Headaches	
Cough		Shortness of breath	
Wheezing			

Other Symptoms:

_____